

cholangitis has been associated with a number of chronic fibrosing inflammatory conditions, including Riedel's thyroiditis (Bartholomew *et al.* 1963).

Hypothyroidism is often subclinical and TMA provides a useful screening test (Hawkins *et al.* 1980), although it has also been shown that there is an increased risk of developing overt myxoedema only if the TSH concentrations are raised as well as the thyroid antibody titres (Tunbridge *et al.* 1981).

Perhaps thyroid antibody titres should be measured in all patients with sclerosing cholangitis and, if raised, the thyroid function further investigated. At the very least, the clinical suspicion of myxoedema in a patient with primary sclerosing cholangitis should now be heightened.

Yours faithfully
V L R TOUQUET

9 September 1983

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Epidermotropic eccrine carcinoma

From Mr J R T Monson and Mr B E Lane
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Dear Sir, The case report by Dr Darley and colleagues (July 1983 *Journal*, page 616) was an interesting example of this rare tumour. We would like to report a further case of this tumour which presented as symmetrical sweat gland carcinomas, which we believe is unique.

A 63-year-old Caucasian woman presented with a nodular skin lesion 2 x 3 cm overlying the medial aspect of the middle third of the tibia on the left side. This had been present for four months, and demonstrated no recent change in size. It was, however, prone to regular bouts of bleeding associated with minimal trauma. On examination, this lesion was not fixed to any of the deep structures and there was no evidence of lymphadenopathy. The patient was also noticed to have a similar lesion in the identical location on the opposite leg. Both of these lesions were widely excised and histology confirmed that they were both mucinous sweat gland adenocarcinomas. This patient has now been followed up for 18 months since presentation and there is

no evidence to date of any local recurrence or of any lymphatic deposits.

Sweat gland adenocarcinoma is a rare primary adnexal neoplasm of the skin with predilection for the face and scalp. Because the appearance of this tumour varies, clinical diagnosis is difficult (Mendoza & Helwig 1971). In a large series of 83 cases with involvement of various parts of the body (Lel-Domeiri *et al.* 1971), each tumour had been present for more than one year in more than half the patients, and almost one-quarter of the patients had regional lymph node metastasis at the time of presentation. Examples of multiple tumours arising in the same patient are unusual (Vutill *et al.* 1971). It remains to be seen whether or not this patient has a tendency to develop further primary skin lesions.

Yours sincerely
JOHN R T MONSON
BRIAN E LANE
23 August 1983

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Mozart's illnesses and death

From Dr Peter J Davies

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Dear Sir, I was most interested to read Dr R Schoental's letter about mycotoxins in the eighteenth century (December 1983 *Journal*, p 1079). With regard to Mozart's illnesses, I would agree that vitamin deficiency may have contributed to his chronic ill health during the last months of his life. Such vitamin deficiency may have resulted from chronic renal failure and reduced intake. With respect, however, I have been unable to find any evidence that Mozart ever suffered symptoms to suggest ergotism or pellagra. Mycotoxins may be capable of causing Schönlein-Henoch syndrome but, to my knowledge, such has not been documented (Cupps & Fauci 1981). In any event, the circumstantial evidence in favour of a streptococcal aetiology in Mozart's case is very strong (see September 1983 *Journal*, p 776).

Yours faithfully
PETER J DAVIES
24 October 1983

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